



Carefree Health Path & Medical Spa

Microdermabrasion & Unique Facials

Last Name: _____ First Name: _____ Date: ____/____/____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Date of Birth: _____ Age: _____ Gender: Female Male
 Email Address: _____ would you like to subscribe to our online special? Y N
 Height _____ Weight _____ Are you: Married Separated Divorced Widowed Single
 Home Phone: _____ Work: _____ Cell: _____
 Emergency Contact: _____ Phone: _____ Relationship _____
 May we communicate with them re: appt's, RX's, and lab results? Y N
 Preferred phone number to contact you: Home Work Cell May we leave a message: Y N
 How did you hear about us? Friend Physician Relative Internet Magazine Other
 Referring person's name: _____
 Are you currently under the care of a physician for a specific condition? Y N If Yes, _____
 Do you have ANY allergies to medications, foods, latex or other substances? Y N If Yes, _____

Skin Conditions: Circle all that apply

- | | | |
|-----------------------|--------------------------------|---------------|
| Taking Blood Thinners | Pregnant/Nursing | Skin Cancer |
| Uncontrolled Diabetes | Viral Lesions (Herpes Simplex) | Hepatitis |
| Sinus Infections | Auto Immune Disease | Dermatitis |
| High Blood Pressure | Low Blood Pressure | Eczema |
| Rash | Lesions | Comedones |
| Redness | Age Spots | Stretch Marks |
| Acne | Enlarged Pores | Scar |
| Milia | Hyperpigmentation | Rosacea |
| Dryness | Sun Damage | Other |

Please explain any items circled: _____
 Please circle products you are currently using: Retin-A, Salicylic Acid, Alpha or Beta Hydroxyl Product, Accutance
 Please list products you are currently using: _____

Patient Consent:

If you have any questions, please ask:

- I acknowledge that no guaranties, either expressed or implied have been made to me regarding the outcome of any treatments or procedures.
- I agree to accept responsibility for payment of all charges relating to the services provided to me. The amounts due for services rendered and that payments must be made directly to Carefree Health Path and that no special arrangements have been made for payment. I understand that all treatments, therapies, medicines and nutritional supplements are non-refundable, and there are no refunds. The services offered are not included in the Medicare program and that if I inadvertently file a Medicare claim it will be denied. Most insurance companies do not pay for these services and any claims I make may be denied.
- I accept t the risks and complications. I agree to follow-up as recommended and to follow any and all of the pre-procedure and/or post-treatment instructions that have been provided to me. I understand that failure to do so can affect my results.
- I have been advised whether, on the days surrounding the treatment or procedure, I should take any and/or all of the medications I informed the doctor I have been taking.
- I understand that some of these therapies are not recognized or approved by the Food and Drug Administration as a standard therapy. I therefore, hereby release Carefree Health Path, and their designates, physician(s), staff, employees, and relatives of such from any liability arriving out of the status of the approval or lack of approval of this therapeutic process.
- As with any therapy, some patients may experience side effects from the therapy(s) chosen and/or agreed to. If they occur, most are likely to be minor or temporary. However, some may be serious or life threatening and need medical attention.

By signing below, you, the patient of Carefree Health Path (or the legal representative or parent of the patients), are requesting and authorizing Carefree Health Path to perform services and to provide you with recommendations on optimizing your present and long-term health goals.

Patient / Legal Guardian Signature: _____ **Date:** ____/____/____

Consent for use and disclosure of health information

Privacy Terms: We keep a record of healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the records we keep. Moreover, if you believe that information in your record is inaccurate, you may request that we make corrections or amend that record. These requests must be made in writing. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Carefree Health Path is required to provide you, at your request, with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have reviewed it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of you healthcare information at our clinic, or wish to inquire about your right, please call the Carefree Health Path at (623) 748-9106.

I hereby acknowledge that I have been offered a copy of the Carefree Health Path Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

Please read the following statements carefully.

Purpose of Consent: By signing this form you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and the uses and disclosures we may make of your protected health information, as well as other important matters regarding your protected health information. A copy of our Notice is available and has been provide with this Consent. We encourage you to read the Notice carefully signing this Consent. We reserve the reserve the right to change our privacy practices as described in our Notice of Privacy Practices at any time. If we change our privacy practices, we will issue a revised Notec of Privacy Practices that will contain the changes. This is in accordance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA Privacy Regulations”)Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of any revisions to our Notice at any time by contracting:

Contact Person: Eugene Eihausen, N.M.D. **Phone:** 623-748-9106

Right to Revoke: You will have the right to revoke this Consent at any time by submitting written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

Notice:

Carefree Health Path and many other organization and individuals including physicians, hospitals and health plans are required by law to keep your health information confidential. If you authorize the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights:

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity’s obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative and delivered to **Carefree Health Path at 2525 W. Carefree Hwy. Bldg. 3, Suite 118, Phoenix, Arizona 85085**. The revocation takes effect when **Carefree Health Path** receives, except to the extent others have already relied on it.

Expiration of Authorization Unless otherwise revoked, this Authorization expires ____/____/____ (insert a date or leave blank). If no date indicated the Authorization expires 12 months after the date of my signing this form.

_____ **(PRINT NAME)** have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that by signing this Consent, I am consenting to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient / Legal Guardian Signature: _____ **Relationship** _____ **Date** ____/____/____

Placed in Chart